## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/28/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01, 02</b>		(X3) DATE SURVEY COMPLETED	
		155689	B. WING _	B. WING		R <b>10/26/2015</b>	
NAME OF PROVIDER OR SUPPLIER  COURTYARD HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 2400 COLLEGE AVE GOSHEN, IN 46526	DDE	.0.20.20.10	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	X (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{K 000}	INITIAL COMMENTS		{K 0	00}			
	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/02/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).  Survey Date: 10/26/15  Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080  At this PSR survey, Courtyard Healthcare Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original section of the building consisting of the A Wing, B Wing, the C wing and the main dining room was surveyed with Chapter 19, Existing Health Care Occupancies.  This one story facility was determined to be of Type V (111) construction and was fully sprinklered with the exception of a storage shed on the roof. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The resident rooms are provided with single station, hard wired smoke detectors. The facility has a capacity of 188 and had a census of 180 at the time of this survey.  All areas where residents have customary access were sprinklered. The facility had two detached, garage sized storage sheds used for storage by the facility that were not sprinklered.						
APODATODY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>	TITI E		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

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		155689	B. WING	B. WING		10/26/2015	
NAME OF PROVIDER OR SUPPLIER  COURTYARD HEALTHCARE CENTER				2	TREET ADDRESS, CITY, STATE, ZIP CODE  400 COLLEGE AVE  GOSHEN, IN 46526		
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{K 000}	Continued From page 1		{K 000}				
{K 000}	Quality Review completed 10/27/15 - DA INITIAL COMMENTS		{K 000}				
	Code Recertification a						
	Survey Date: 10/26/1	5					
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NAME OF B	201/1252 02 01/1251 155	100000			OTDEET ADDRESS OFFI OTATE TIP CODE	10/	26/2015
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
COURTYA	RD HEALTHCARE CENT	ER			2400 COLLEGE AVE		
			GOSHEN, IN 46526				
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		2				ATE .	DATE